



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

October 1, 2007

Catherine Johnson, Administrator
Aspen Grove Assisted Living - Idaho Falls
2705 E 17th St
Idaho Falls, ID 83406

License #: RC-584

Dear Ms. Johnson:

On August 22, 2007, a complaint investigation survey was conducted at Aspen Grove Assisted Living - Idaho Falls. As a result of that survey, deficient practices were found. The deficiencies were cited at the following level(s):

- Core issues, which are described on the Statement of Deficiencies, and for which you have submitted a Plan of Correction.

This office is accepting your submitted plan of correction.

Should you have questions, please contact Donna Henscheid, LSW, Health Facility Surveyor, Residential Community Care Program, at (208) 334-6626.

Sincerely,

DONNA HENSCHIED, LSW
Team Leader
Health Facility Surveyor
Residential Community Care Program

DH/sc

c: Jamie Simpson, MBA, QMRP Supervisor, Residential Community Care Program



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

September 5, 2007

CERTIFIED MAIL #: 7003 0500 0003 1967 0636

Catherine Johnson, Administrator
Aspen Grove Assisted Living - Idaho Falls
2705 E 17th St
Idaho Falls, ID 83406

Dear Ms. Johnson:

Based on the complaint investigation survey conducted by our staff at Aspen Grove Assisted Living - Idaho Falls on **August 22, 2007**, we have determined that the facility failed to retain an administrator for a period more than 30 days. Additionally, the facility failed to protect residents from inadequate care. Based on observation, interview and record review, it was determined the facility failed to provide supervision to sampled residents (#1&2). The facility's lack of supervision had the potential to endanger and cause harm to 100% of the residents. Further, resident rights were not protected because the facility failed to provide a safe and sanitary environment for all residents. This failure had the potential to affect 100% of the residents in the facility. Additionally, the facility failed to develop an NSA/BMP to describe how the hygiene needs would be met for Resident #1.

These core issue deficiencies substantially limit the capacity of Aspen Grove Assisted Living - Idaho Falls to furnish services of an adequate level or quality to ensure that residents' health and safety are safe-guarded. The deficiency is described on the enclosed Statement of Deficiencies.

You have an opportunity to make corrections and thus avoid a potential enforcement action. Correction of this deficiency must be achieved by **October 7, 2007**. **We urge you to begin correction immediately.**

After you have studied the enclosed Statement of Deficiencies, please write a Plan of Correction by answering **each** of the following questions for **each** deficient practice:

- ♦ What corrective action(s) will be accomplished for those specific residents/personnel/areas found to have been affected by the deficient practice?
- ♦ How will you identify other residents/personnel/areas that may be affected by the same deficient practice and what corrective action(s) will be taken?
- ♦ What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur?

- ♦ How will the corrective action(s) be monitored and how often will monitoring occur to ensure that the deficient practice will not recur (i.e., what quality assurance program will be put into place)?
- ♦ What date will the corrective action(s) be completed by?

Return the **signed** and **dated** Plan of Correction to us by **September 18, 2007**, and keep a copy for your records. Your license depends upon the corrections made and the evaluation of the Plan of Correction you develop.

In accordance with Informational Letter #2002-16 INFORMAL DISPUTE RESOLUTION (IDR) PROCESS, you have available the opportunity to question cited deficiencies through an informal dispute resolution process. If you disagree with the survey report findings, you may make a written request to the Chief of the Bureau of Facility Standards for a Level 1 IDR meeting. The request for the meeting must be made within ten (10) business days of receipt of the statement of deficiencies (**September 18, 2007**). The specific deficiencies for which the facility asks reconsideration must be included in the written request, as well as the reason for the request for reconsideration. The facility's request must include sufficient information for the Bureau of Facility Standards to determine the basis for the provider's appeal. If your request for informal dispute resolution is received after **September 18, 2007**, your request will not be granted.

If, at the follow-up survey, it is found that the facility is not in compliance with the rules and standards for residential care or assisted living facilities, the Department will have no alternative but to initiate an enforcement action against the license held by Aspen Grove Assisted Living - Idaho Falls.

Should you have any questions, or if we may be of assistance, please call our office at (208) 334-6626.

Sincerely,



JAMIE SIMPSON, MBA, QMRP
Supervisor
Residential Community Care Program

JS/slc

Enclosure

c: Melanie Belnap, Program Manager, Regional Medicaid Services, Region VII - DHW

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FALLS			STREET ADDRESS, CITY, STATE, ZIP CODE 2705 E 17TH ST IDAHO FALLS, ID 83406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 000	Initial Comments The following core deficiencies were cited during the complaint investigation survey conducted at your residential care/assisted living facility on 8/22/07. The surveyors conducting your survey were: Donna Henscheld, LSW Team Coordinator Health Facility Surveyor Rachel Corey, RN Health Facility Surveyor Karen McDannel, RN Health Facility Surveyor Survey Definitions: BM = bowel movements BMP = behavior management plan COPD = cardiopulmonary disease LPN = licensed practical nurse MAR = Medication Administration Record mg = milligrams NSA = Negotiated Service Agreement PO = By Mouth PRN = As Needed pt. = patient rm = room RN = registered nurse	R 000			
R 004	16.03.22.215.03 Licensed Administrator Requirement - 30 Days The facility may not operate for more than thirty (30) days without a licensed administrator.	R 004	R004 Current Administrator in training, Catherine Johnson, LPN, obtained a temporary permit number TRCA1356 valid August 09, 2007 through November 09, 2007. The facility has hired a new Administrator with a current Administrator license. New Administrator to begin full-time employment and facility oversight, effective October 15, 2007.		

Bureau of Facility Standards

TITLE

(X8) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

STATE FORM

6889

KNRJ11

If continuation sheet 1 of 14

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2705 E 17TH ST IDAHO FALLS, ID 83406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R 004	Continued From page 1 This Rule is not met as evidenced by: Based on interview and observation it was determined the facility failed to retain a licensed administrator responsible for the day-to-day operations for a period more than 30 days. Upon the initial tour the current administrator's provisional license was observed and dated August 9, 2007. A Provisional license is valid for a 30 day period of time. On 8/22/07 at 9:00 a.m., the facility's administrator and support staff stated that prior to the current administrator, the facility has not had a licensed administrator since January 2007. On 8/22/2007 at 10:30 a.m., the administrator stated she had been the acting administrator since 5/22/07 and confirmed she had not been issued a provisional license until 8/9/07. The facility had operated without a licensed administrator responsible for the day-to-day operations for more than 30 days.	R 004			
R 008	16.03.22.520 Protect Residents from Inadequate Care. The administrator must assure that policies and procedures are implemented to assure that all residents are free from inadequate care. This Rule is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide supervision to sampled residents (#1 & 2). The facility's lack of supervision had the potential to endanger and cause harm to 100% of the residents. Further, resident rights were not	R 008	R008 The Administrator, Vice President, Consulting Nurse and a Consulting Administrator and facility staff have reviewed policies and procedures and staff have received in-service training as to use of such to assure that all residents are free from inadequate care. Resident #'s 1 and 2 were assigned 24 hour one-to-one staffing, August 22, 2007 to assure safety and appropriate care. All resident records, including Negotiated Service Agreements (NSA) and Behavior Management Plans (BMP) have been reviewed and residents assessed to determine appropriateness and adequacy to current special needs and/or behaviors. Administrative staff has received in-service training as to the completion of NSA's and BMP's. Concurrent to review, all current residents' NSA's are complete and updated, and implemented through staff orientation and in-service specific to each resident's needs.		

Bureau of Facility Standards
STATE FORM

6500

KNRJ11

If continuation sheet 2 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2705 E 17TH ST IDAHO FALLS, ID 83406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R 008	<p>Continued From page 2</p> <p>protected because the facility failed to provide a safe and sanitary environment for all residents. This failure had the potential to affect 100% of the residents in the facility. Additionally, the facility failed to develop an NSA /BMP to describe how the hygiene needs would be met for Resident #1.</p> <p>1. SUPERVISION</p> <p>A. Resident #1 was admitted on 12/01/06 with diagnoses which included the following: COPD and forgetfulness.</p> <p>The facility smoking policy documented the following: "Smoking is never allowed near where flammable liquids, gasses or oxidizers are in use or stored where anything combustible is stored. If a resident is caught violating the smoking policy, then one written warning will be issued. The next violation will be grounds for immediate vacate notice."</p> <p>The facility "Behavior Plan" for Resident #1 (undated), documented the following behavioral concerns: "He responds with verbal outbursts against the staff. He also has a problem with smoking in his room." Interventions documented were for "administration to set boundaries."</p> <p>An incident/accident report dated 12/28/06 documented "...smell of cigarette smoke in (resident's name) rm. So we finished our rounds and came back and asked him if he was smoking in his rm. He said no. Reinforced it was against company policy. Evidence found sitting next to his bed."</p> <p>An incident/accident report dated 1/9/07 documented "...appears that resident is smoking in his room and can smell smoke in the hall."</p>	R 008	<p>All future potential admits will have a screening assessment completed prior to admission, and, as per policy, upon admission, and 14 days from admission, continuing as needed. Admission process will be monitored as follows:</p> <p>For a period of 6 months, new admits will only be allowed after all necessary paperwork is completed and reviewed by VP and Consulting Nurse. VP and/or designee, and/or Consulting Nurse will perform a monthly review of all patient records -- to assure NSA's, BMP's and all other documents as needed are appropriate and completed correctly.</p> <p>A revised BMP was completed and implemented for Resident #1 and staff received in-service training specific to this resident's hygiene and safety needs on August 23, 2007. In addition all staff received in-service training regarding general resident hygiene and safety. One-to-one, 24 hour staffing was begun on August 22, 2007. Observation of behaviors indicated need for an updated BMP and NSA; completed 09/13/07 that addresses specific hygiene and smoking behaviors.</p> <p>Oxygen tanks and supplies have been removed from patient rooms and are stored in a designated storage area. No extra oxygen tanks remain in resident rooms. All are stored, upright in containers specifically designed to prevent tipping, and are appropriately marked for resident identification and tracking purposes.</p> <p>A special Resident Council meeting has been scheduled for October 04, 2007, to include residents, staff, resident families, case workers, representatives from Adult Protective Services and the Ombudsman for the Elderly, to review facility policies and standards regarding safety, smoking policies, and rules and expectations for general cleanliness and personal hygiene.</p> <p>Staff received in-service training regarding resident and environmental safety concerns, including incident and accident reporting protocol, life safety code requirements.</p> <p>Staff participation will be documented through the use of staff sign-in sheets. Attendance will be mandatory in accordance with existing facility policy.</p>		

Bureau of Facility Standards
 STATE FORM

5889

KNRJ11

If continuation sheet 3 of 14

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2705 E 17TH ST IDAHO FALLS, ID 83406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 008	<p>Continued From page 3</p> <p>An incident/accident report dated 2/6/07 documented "...was walking by doing rm checks, didn't find nothing, but you can smell it really bad when you walk in the hall room by spa rm."</p> <p>An incident/accident Report dated 2/10/07 documented "we smelled fresh smoke while doing room checks, when we entered the room he was in his bathroom. We went outside and we saw him through his window smoking in his room..." Following this incident the resident and his daughter were informed the facility would have to take his cigarettes away if his behaviors continued.</p> <p>An incident/accident Report dated 4/26/07 documented "resident (resident's name) lit up a cigarette inside the building with his oxygen still on and in his mouth."</p> <p>A behavior communication log dated 5/11/07 documented "he was smoking in his room again. I took his urinal out with cigarette butts in it again. Told him he couldn't have back. He called me everything but a white woman very agitated." The intervention documented "...took cigarettes away, we will be giving them to him from now on."</p> <p>An incident/accident report dated 5/13/07 documented "...she could smell smoke outside resident's (resident's name) room. Staff (staff's name) unlocked door to check. Staff (staff's name) could smell a strong smoke smell and could see resident's (resident's name) urinal had a little bit of black looking water in the bottom."</p> <p>An incident/accident report dated 7/8/07 documented "...saw resident (resident's name) pull a pack of cigarettes out of his shirt pocket."</p>	R 008	<p>Quality assurance monitoring will consist of weekly safety and hygiene checks, performed by the Administrator, for a period of one-month, and will continue monthly thereafter. A record of such monitoring will be maintained in the facility administrative office. Needed corrective actions will be taken immediately under the direction of the Administrator. Oversight will be performed by and through the formation of a Quality Assurance committee.</p> <p>A Quality Assurance committee has been formed to monitor and improve quality, training and education issues throughout the facility. All staff in-service training will be documented and results reviewed as part of the monthly quality review component. Committee consists of the facility Administrator, facility Nurse, Lead Aid, with oversight by the VP and/or Consulting Nurse or designee.</p> <p>On September 07, 2007, following one-to-one 24-hour staffing and monitoring of resident #1's behaviors, a meeting was called with the resident's family member, the Ombudsman for the Elderly, a representative from Adult Protective Services, the facility Administrator, and VP, to discuss resident hygiene and general health behaviors and non-compliance with facility smoking policies. Plan for psychological evaluation and possible temporary placement in psychological hospital for that purpose was discussed. It was determined that one-to-one 24-hour staffing/monitoring would continue.</p> <p>On September 13, 2007 an update to Resident #1's NSA and BMP was completed. Staff in-service training was received September 13 and 14 specific to the revised BMP and NSA for Resident #1.</p> <p>On September 14, 2007, after receiving resident #1's approval, and in conjunction with resident family representative, a representative from the office of the Ombudsman for the Elderly and Adult Protective Services, a physician order was secured and arrangements were made for resident #1's admission to a hospital specializing in psychological evaluation and treatment was secured.</p>		

Bureau of Facility Standards
STATE FORM

8800

KNRJ11

If continuation sheet 4 of 14

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FAI		STREET ADDRESS, CITY, STATE, ZIP CODE 2705 E 17TH ST IDAHO FALLS, ID 83406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	(X5) COMPLETE DATE	
R 008	<p>Continued From page 4</p> <p>We wondered how he got them and we searched his room and found three unopened packs of cigarettes. They were in the bottom drawers of his dress underneath some sweaters. We pulled them out and put them in med cart. He later came to the med room and asked where they were because he claims that he was going to bring them to us. He also said that his daughter brought them to him. He got mad that we had gone through his drawers. He said the next person he caught going through his drawers would get their (expletive) hands cut off." It was also documented that the LPN talked with him once again about the rules regarding smoking, reminded him to hand over all cigarettes to the facility and facility would continue to monitor the situation.</p> <p>On 8/22/07 at 8:30 a.m., Resident #1's room was observed to contain 24 large portable oxygen tanks and an oxygen concentrator. There was a large 2 foot brown stain beside his bed with a one inch burn mark near the edge of the stain and three partially smoked cigarette butts on the carpeted floor.</p> <p>On 8/22/07 at 9:00 a.m., the resident was observed to have cigarette burns marks on his shirt, his nails were long and filled with brown substance, his hands were nicotine stained and a pack of cigarettes was observed in his shirt pocket.</p> <p>On 8/22/07 at 10:15 a.m., the house manager stated she had caught resident smoking in his room on 1/24/07 and other staff had caught him smoking at 7:00 a.m. this morning.</p> <p>On 8/22/07 at 10:30 a.m., the administrator and corporate staff were informed of the immediate</p>	R 008	<p>R008, continued, top of pg. 5</p> <p>Staff training on resident rights, Ombudsman and Adult Protective Services, and facility notification policies will be completed by September 19, 2007. The results of training activities and resultant behaviors will be tallied, as evidenced by internal quality assurance audits, and reported monthly to the Quality Assurance committee and training needs assessed and continuing education programs designed for further training sessions. Continuing education sessions will be offered monthly beginning October, November, and December, 2007 and continuing quarterly thereafter. Material will be mandatory for all newly hired employees.</p> <p>All staff in-service training and education will be monitored by the Quality Assurance committee. A Quality Assurance committee has been formed to monitor and improve quality, training and education issues throughout the facility. All staff in-service training will be documented and reviewed as part of the monthly quality review component. Committee consists of the facility Administrator, facility Nurse, Lead Aid, with oversight by the VP and/or the Consulting Nurse or designee.</p> <p>Oxygen tanks and supplies have been removed from patient rooms and are stored in a designated storage area. No extra oxygen tanks remain in resident rooms. All are stored, upright in containers specifically designed to prevent tipping, and are appropriately marked for resident identification and tracking purposes. Oxygen tank storage and use will be monitored by the Administrator and under the oversight of the newly created Quality Assurance committee.</p> <p>All carpets in the facility have been shampooed. Carpets were professionally cleaned on August 29, 2007. Facility will maintain carpet cleaning per monthly maintenance schedule and as needed with facility owned carpet shampooer, and annual professional servicing.</p> <p>Carpets with stains and burn marks that cannot be repaired will be replaced by October 01, 2007.</p> <p>On September 13, 2007 an update to Resident #1's NSA and BMP was completed. Resident agreed to shower twice per week and to staff assistance with set-up. Staff in-service training was received September 13 and 14 specific to the revised BMP and NSA for Resident #1.</p> <p>Resident care task sheets have been developed and will be implemented and staff will be trained on their use by October 01. Task sheets correlate with the NSA and any BMP's in identification and documentation of specific cares and assistance needed with activities of daily living. Completed task sheets will become part of the patient record. The facility Administrator and Consulting Nurse will review task sheets and all identified issues will be immediately corrected, staff in-service trained for best practices, and results reported monthly to the Quality Assurance committee.</p>	

Bureau of Facility Standards
STATE FORM

8299

Sheet 5 of 14

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R564	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2705 E 17TH ST IDAHO FALLS, ID 83406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R 008	<p>Continued From page 5</p> <p>danger due to the evidence Resident #1 had been smoking his bedroom with multiple oxygen tanks present and where he used continuous oxygen. This had the potential to cause danger to the entire facility. The immediate danger situation was corrected by removing the excess oxygen tanks from the resident's room and providing 1-1 supervision to Resident #1.</p> <p>B. Resident #2 was admitted on 7/13/04 with diagnoses which included the following: developmentally delayed, chronic schizophrenia (paranoid type) and dementia.</p> <p>Resident #2's NSA dated 7/13/07, documented the following:</p> <p>Night Needs: "Needs no assistance from another person during the night... Independent..."</p> <p>Emergency Response: "Caregiver must assist to go outside of present dwelling, but client can assist...Frequency: Needs verbal cueing to safety and constant supervision for safety."</p> <p>Supervision: Requires frequent verbal cues/prompts...Frequency: Needs behavior redirection often."</p> <p>Behavioral Management: "Resident's concerns for wandering..."</p> <p>The facility's "Behavior Plan" (undated) under brief social history states, "Resident has never been able to function in society without supervision...Did attention seeking by laying in the middle of the road until police came...Behavior Concerns: Up at night time because he can't sleep, becomes easily upset if can't go outside..." The re-direction techniques were to offer walks around the facility area on weekends.</p>	R 008	<p>R008 cont'd - top of page 6</p> <p>Oxygen tanks and supplies have been removed from patient rooms and are stored in a designated storage area. No extra oxygen tanks remain in resident rooms. All are stored, upright in containers specifically designed to prevent tipping, and are appropriately marked for resident identification and tracking purposes. Oxygen tank storage and use will be monitored under the oversight of the newly created Quality Assurance committee.</p> <p>B. Resident #2 pg. 6 of 14</p> <p>Resident #2 was placed under one-to-one, 24 hour supervision effective August 22, 2007 and will continue under such supervision measures are in place to assure resident safety without being so supervised.</p> <p>A revised BMP was completed for Resident #2 and staff in-service training was received specific to this resident's safety and activities of daily living.</p> <p>Bids have been received and are being reviewed for a "Wander-Guard" type security system that will allow resident to dwell freely and safely within the facility, without the aid of one-on-one supervision. New front doors are on order and are scheduled to be installed mid-October. Doors are of a variety that will lend to a more pleasing atmosphere, and be easily equipped with a magnetic locking device in conjunction with the "Wander-Guard" security system.</p>		

Bureau of Facility Standards
STATE FORM

6899

KNRJ11

If continuation sheet 6 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2705 E 17TH ST IDAHO FALLS, ID 83406		
(X4) ID PREFIX TAG R 008	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		ID PREFIX TAG R 008	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
	<p>Continued From page 6</p> <p>On 3/7/2007, the facility nurse faxed a statement to the physician regarding the resident's behaviors which documented, "he was trying to get out of the garden and on his rides he tries to open the doors, yells not to stop at lights, and won't wear his seatbelt."</p> <p>On 3/7/07, the physician assistant's report documented, "He wants to escape out the door everytime he gets a chance."</p> <p>On 8/16/07 at 1:00 p.m., a care note reported that the resident "escaped..." There was no further documented evidence of how the staff responded to the elopment.</p> <p>On 8/22/07 at 9:20 a.m., Resident #2 was observed laying on the floor in the hallway. The caregiver led him outside to an isolated patio off the unoccupied wing stating, "Let's go out to the sunshine." Staff left the area and the resident was observed sitting alone. The patio was scattered with multiple debris, including a broken handrail, broken chairs, a broken planter box and multiple yard tools.</p> <p>On 8/22/07 at 9:45 a.m., 3 doors that lead to an unsecured yard were observed to be unsecured. The open access from the yard led directly to a busy street.</p> <p>On 8/22/07 at 10:30 a.m., the administrator and corporate staff were informed of the immediate danger related to Resident #2's history of elopement, having an unsecured environment and lack of supervision. They acknowledged the immediate danger situation and corrected the situation by providing 1-1 supervision.</p> <p>The facility's administrator failed to assure that</p>			<p>R008 cont'd = top of page 7</p> <p>Resident #2 continues with 24 hour one-to-one supervision and will continue under such supervision until measures are in place to assure resident safety without being so supervised. Since being placed under such supervision, resident has responded with no unpleasant interactions or wander attempts.</p> <p>A BMP has been created to address lying on the floor in the hallway. This behavior has also significantly decreased since the initiation of one-to-one staffing and the revised BMP.</p> <p>Facility and facility grounds have been updated as follows to assure resident rights for a safe and sanitary environment have been preserved. The following will also be monitored under the direction of the Administrator and/or designee. Corrective actions will be taken immediately as needed and reported monthly to the Quality Assurance committee:</p> <p>All facility property has been cleaned up and made appropriate for resident use. Specifically:</p> <ol style="list-style-type: none"> Patio debris including broken handrail, broken chairs, broken planter box and multiple yard tools, have either been repaired, discarded, and tools properly stored. Bids have been received for construction of a fence to prevent otherwise open access from yard areas to a busy front street. Fence construction to be completed by October 07, 2007. Bids have been received and are being reviewed for a "Wander-Guard" type security system that will allow resident to dwell freely and safely within the facility, without the aid of one-on-one supervision. New front doors are on order and are scheduled to be installed mid-October. Doors are of a variety that will lend to a more pleasing atmosphere; and be easily equipped with a magnetic locking device in conjunction with the "Wander-Guard" security system. 	

Bureau of Facility Standards
 STATE FORM

6899

Continuation sheet 7 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2705 E 17TH ST IDAHO FALLS, ID 83406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R 008	<p>Continued From page 7</p> <p>Residents #1 & #2 received adequate supervision.</p> <p>II. RESIDENT RIGHTS - SAFE AND SANITARY ENVIRONMENT</p> <p>The Daily Job Lists for three different shifts included the following tasks: 6:00 a.m. to 2:00 p.m. shift documented that housekeeping was to be done between 9:00 a.m. and 11:45 a.m., the 2:00 p.m. to 10:00 p.m. shift documented that housekeeping (hall to dining room) would be done between 2:00 p.m. to 4:00 p.m., and the 10:00 p.m. to 6:00 a.m. Job List documented the lounge rooms, restrooms, foyer, dining room, break room and patio area would be vacuumed, cleaned and dusted. However, the Daily Job List check sheets were blank.</p> <p>A. On 8/22/07 during the initial tour and throughout the survey, the following interior environmental concerns were observed:</p> <p>Room #1: The caulking around the toilet was observed to be coming off.</p> <p>Room #6: Pink stains were observed on the floor and the bathroom counter was covered with a film of dirt.</p> <p>Room #9: A large 2 foot brown stain in the carpet was observed beside the bed, a 1 inch burn mark was observed in the carpet, and a urine container that was 1/2 full was attached to bed. Additionally, there was a strong urine odor in the room and bathroom, and clothing was piled on the floor in front of the dresser.</p> <p>Room #11: No sheets were observed on the bed.</p>	R 008	<p>d. Facility task sheets have been revised to reflect current needs of residents. Staff training and in-service training to be completed on the use of revised task sheets by October 05, 2007.</p> <p>e. All resident rooms and facility common areas to be deep-cleaned and necessary maintenance completed by October 07, 2007.</p> <p>f. Room #1 - Caulking around the toilet is complete. All resident rooms have been inspected, needed repairs noted and completed.</p> <p>g. Room # 6 - Bathroom counter has been scoured and carpet will be replaced no later than October 01, 2007.</p> <p>h. Room #9 - Room has been scoured and carpet will be replaced no later than October 01, 2007. Staff has received in-service training on sanitary waste handling practices.</p> <p>i. Room # 11 was unoccupied at time of survey. Staff has received in-service education on the necessity of providing a clean and sanitary environment, to include sheets on empty beds, at all times throughout the facility.</p> <p>j. Room 15 - The closet door has been repaired and re-hung</p> <p>k. Room 16 - Vanity mirror and counter has been scoured and de-cluttered. Soap scum has been removed from the shower. Stained recliners have been removed and replaced with clean furniture in good working order. Carpet will be replaced no later than October 01, 2007.</p> <p>l. All broken furniture, doors, shelving, etc. to be repaired and/or replaced by October 07, 2007.</p>		

Bureau of Facility Standards
 STATE FORM

2030

KNRJ11

If continuation sheet 8 of 14

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FAI		STREET ADDRESS, CITY, STATE, ZIP CODE 2705 E 17TH ST IDAHO FALLS, ID 83408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	<p>Continued From page 8</p> <p>Room #15: The closet door was broken and leaning against the wall.</p> <p>Room #16: The vanity mirror was smudged and dirty. The vanity counter was cluttered and dirty. There was a large stain on the carpet and the closet door was broken. Soap scum was present in the shower. Two recliners were stained and clothes were piled up on top of a dresser.</p> <p>Room #17: Soap scum was present in the shower. A long pole used for stability and transfers was observed unattached to the floor and leaning against the wall. The carpet was speckled with debris.</p> <p>Room #18: The bathroom exhibited a strong odor and the toilet upon flushing, let out a howling noise.</p> <p>Room #19: Multiple dark, greasy carpet stains were present and a strong odor was evident in the bathroom.</p> <p>Room #22: The entire room had a strong musty smell.</p> <p>Several rooms contained tan vanity chairs that were very worn and stained.</p> <p>The carpeting throughout the facility was stained and worn.</p> <p>The unoccupied wing of the facility was unlocked and accessible to residents. Two rooms in the unoccupied wing were full of boxes of miscellaneous supplies, such as paint, glue, extra furniture and kitchen supplies.</p> <p>Throughout the facility several windows and</p>	R 008	<p>m. Room #17 – Soap scum has been removed from the shower. Carpet has been cleaned and the leaning, unattached stability and transfer pole has been removed from the resident room and stored appropriately.</p> <p>n. Room #18 – room has been deep cleaned and toilet was repaired August 24, 2007. A new cat litter box has been obtained and cat has been trained on proper care – effective 09/13/07. Staff to monitor daily to ensure proper pet hygiene and maintenance. Staff has received in-service training as to this specific monitoring requirement.</p> <p>o. Room #19 – carpet has been cleaned and room has been deep cleaned and sanitized.</p> <p>p. Room #22 – carpet has been cleaned and room has been deep cleaned and sanitized.</p> <p>q. Tan vanity chairs throughout facility have either been cleaned or discarded and replaced.</p> <p>r. Carpets throughout the facility were professionally cleaned on August 29, 2007. Facility will maintain per monthly maintenance schedule and as needed with facility owned carpet shampooer, and annual professional servicing. Carpets with stains and burn marks that cannot be repaired will be replaced by October 01, 2007.</p> <p>s. The unoccupied wing of the facility has been cleaned, straightened, organized and otherwise made ready for resident occupancy as determined by facility need.</p>	

Bureau of Facility Standards
 STATE FORM

0830

KNRJ11

If continuation sheet 9 of 14

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FAI		STREET ADDRESS, CITY, STATE, ZIP CODE 2705 E 17TH ST IDAHO FALLS, ID 83406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	<p>Continued From page 9</p> <p>sliding glass doors were smudged and dirty.</p> <p>B. Exterior environment:</p> <p>The storage shed located in the west yard was unlocked and contained gasoline and yard chemicals. A riding lawnmower, with the keys in the ignition, was sitting on the sidewalk next to the shed blocking the exit. There was trash observed beside the exit door.</p> <p>The fence surrounding the yard was missing multiple boards. Some of the boards, with nails sticking up out of them, were observed laying face up in front of another exit.</p> <p>The patio located off of the unoccupied wing was scattered with multiple debris, including a broken handrail, broken chairs, a broken planter box and multiple yard tools present. Most of the patio furniture was dirty, worn or damaged.</p> <p>On 8/22/07 at 8:45 a.m., a random resident stated his closet door had been broken for "two to three months."</p> <p>On 8/22/07 at 9:00 a.m., a caregiver stated the facility did not have staff specific to perform just housekeeping. The caregiver stated her responsibilities included housekeeping, caregiving, cleaning bathrooms, making beds and passing medications.</p> <p>On 8/22/07 at 9:35 a.m., the administrator stated the maintenance man had just started work on 8/21/07.</p> <p>8/22/07 at 11:00 a.m., the administrator confirmed the Daily Job List check sheets were not completed.</p>	R 008	<p>t. Facility sliding glass doors and glass windows have been cleaned and washed, and window blinds have been scoured and sanitized. Glass maintenance will be added to and monitored as part of the quality assurance process.</p> <p>u. The storage shed located in the west yard has been refurbished with a newly built door and padlock device. Lawn mower, gasoline and other lawn chemicals kept inside the shed under padlocked protection. The storage shed and all other storage shed on the facility have received needed repairs and a fresh coat of paint.</p> <p>v. Missing fence boards have been replaced, nails either removed or pounded flush with the wood and fence has received a new coat of paint.</p> <p>w. Patio debris including broken handrail, broken chairs, broken planter box and multiple yard tools, have either been repaired, placed out of harm's way or discarded.</p> <p>x. All room doors and closet doors have been repaired or replaced.</p> <p>y. Routine maintenance schedule to be updated for prevention and health maintenance practices by October 05, 2007.</p> <p>z. Staff to receive infection control and universal precautions in-service training on September 19, 2007.</p>	

Bureau of Facility Standards
STATE FORM

6899

KNRJ11

If continuation sheet 10 of 14

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2705 E 17TH ST IDAHO FALLS, ID 83406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R 008	<p>Continued From page 10</p> <p>The facility did not ensure that rights of the residents were protected by providing them with a safe and sanitary living environment.</p> <p>III. NSA/BMP</p> <p>Resident #1's NSA (undated) documented the resident managed his own personal hygiene but required verbal cueing. He also required cueing to change clothing at times and was able to bathe himself when reminded.</p> <p>Resident #1's monthly nursing assessment dated 7/26/07 documented the resident became agitated, was disruptive with staff at times, was noncompliant with cares at times and lost temper quickly. It also identified the resident as having "poor dental hygiene and poor personal hygiene."</p> <p>The facility "Behavior Plan" for Resident #1 (undated), documented the following behavioral concerns: "...has a temper problem if his medication is not ready when he comes down to get them. He responds with verbal outbursts against the staff." The "Behavior Plan" did not include a system for tracking or monitoring behaviors and the only intervention documented was the following: "Interventions with administration to set boundaries."</p> <p>The "Resident Communication Log" dated 3/11/07 documented "...resident (resident's name) had BM all over his pants from diarrhea. I asked him if he would let me wash them. He was mad but he let me and he will not take a shower till tomorrow. He smells really bad like BM."</p> <p>A monthly nursing assessment dated 6/11/07 documented Resident #1's appearance as</p>	R 008	<p>R008 cont'd - top of page 11</p> <p>Based upon policy reviews and implementation of quality corrections and measures so noted, all residents are provided with a safe and sanitary living environment.</p> <p>Section III</p> <p>All resident NSA's and BMP's will be made current with recent changes by September 30, 2007. Staff in-service training on use of NSA's and BMP's was provided September 13 and 14, 2007 with ongoing training provided as needed with changes in behavior or needed levels of care.</p> <p>In-service training will be given September 19, 2007 regarding staff to resident interaction, to be reviewed monthly for one quarter and continuing quarterly thereafter.</p> <p>Staff compliance with NSA and BMP requirements will be monitored daily by facility Administrator, upon visit by the facility consulting nurse and VP and monthly by the Quality Assurance committee.</p> <p>All staff in-service training and education will be monitored by the Quality Assurance committee. A Quality Assurance committee has been formed to monitor and improve quality, training and education issues throughout the facility. All staff in-service training will be documented and reviewed as part of the monthly quality review component. Committee consists of the facility Administrator, facility Nurse, Lead Aid, with oversight by the VP.</p>		

Bureau of Facility Standards
STATE FORM

8899

KNRJ11

If continuation sheet 11 of 14

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2703 E 17TH ST IDAHO FALLS, ID 83408		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE
R 008	<p>Continued From page 11</p> <p>"unkept (sic), requires a lot of cueing for proper hygiene."</p> <p>An "Emergency Room Report" dated 06/29/07 documented "pt. is extremely dirty with feces and urine on legs and clothing."</p> <p>Resident #1's monthly nursing assessment dated 7/26/07 documented resident was non-compliant with cares and had poor dental and personal hygiene.</p> <p>Resident #1's daily log for the August 8:00 a.m. to 2:00 p.m. shift documented all "Ns" for personal hygiene, dressing, bathing and toileting. The "N" was identified as the code to use when no assistance was needed.</p> <p>Resident #1's daily log for the August 2:00 p.m. to 10:00 p.m. shift documented all "Ns" for toileting, personal hygiene and dressing.</p> <p>Resident #1's daily log for the August 10:00 p.m. to 6:00 a.m. shift documented all "Ns" for toileting, hygiene, dressing and "NA" (not applicable) for bathing.</p> <p>The 2:00 p.m. to 10:00 p.m. "Shower and Bed Change Schedule" dated August 6th - 12th, 2007 documented the resident received a shower and bed change 1 out of 3 times scheduled.</p> <p>The 2:00 p.m. to 10:00 p.m. "Shower and Bed Change Schedule" dated August 13th - 19th, 2007 documented the resident received a shower and bed change 1 out of 3 times scheduled.</p> <p>There was no documentation on the 2:00 p.m. to 10:00 p.m. "Shower and Bed Change Schedule" dated August 20th - 26th, 2007. This indicated</p>	R 008	<p>R008 continued - top of page 12</p> <p>Resident #1 was assigned 24 hour one-to-one staffing, August 22, 2007 to assure safety and appropriate care. All resident records, including Negotiated Service Agreements (NSA) and Behavior Management Plans (BMP) have been reviewed and residents assessed to determine appropriateness and adequacy to current special needs and/or behaviors. Administrative staff has received in-service training as to the completion of NSA's and BMP's. Concurrent to review, all current resident NSA's are complete and updated, and implemented through staff orientation and in-service specific to resident need.</p> <p>All future potential admits will have a screening assessment completed prior to admission, and, as per policy, upon admission, and 14 days from admission, continuing as needed. Admission process will be monitored as follows:</p> <p>For a period of 6 months, new admits will only be allowed after all necessary paperwork is completed and reviewed by VP or Consulting Nurse, VP and/or designee, and/or Consulting Nurse will perform a monthly review of all patient records - to assure NSA's, BMP's and all other documents as needed are appropriate and completed correctly.</p> <p>A revised BMP was completed and implemented for Resident #1 and staff received in-service training specific to this resident's hygiene and safety needs and staff and resident hygiene and safety needs in general, on August 23, 2007. One-to-one, 24 hour staffing was begun on August 22, 2007. Observation of behaviors indicated need for an updated BMP and NSA, completed 09/13/07 that addresses specific hygiene and smoking behaviors. Oxygen tanks and supplies have been removed from patient rooms and are stored in a designated storage area. No extra oxygen tanks remain in resident rooms. All are stored, upright in containers specifically designed to prevent tipping, and are appropriately marked for resident identification and tracking purposes.</p> <p>Quality assurance monitoring will consist of weekly safety and hygiene checks, performed by the Administrator, for a period of one-month, and will continue monthly thereafter. A record of such monitoring will be maintained in the facility administrative office. Needed corrective actions will be taken immediately under the direction of the Administrator. Oversight will be performed by and through the formation of a Quality Improvement committee.</p>		

Bureau of Facility Standards
STATE FORM

0000

K Administrator. Oversight will be performed by and through the formation of a Quality Improvement committee.

set 12 of 14

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FAI		STREET ADDRESS, CITY, STATE, ZIP CODE 2705 E 17TH ST IDAHO FALLS, ID 83406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 008	<p>Continued From page 12</p> <p>the resident had not been assisted with a shower or bed change as scheduled.</p> <p>On 8/22/07 at 8:55 a.m., Resident #1 was observed in a dirty red shirt, his hair was greasy and was speckled with white flakes, his mouth was full of a thick white frothy substance and his teeth were covered with a yellow build-up of plaque. His nails were long and filled with a brown substance.</p> <p>On 8/22/07 at 9:10 a.m., a caregiver confirmed that Resident had behaviors related to hygiene issues and stated, he was often "dirty" because "he doesn't like to bathe or change his clothes."</p> <p>The facility did not implement the NSA nor develop a BMP to address Resident #1's poor personal hygiene. The NSA/BMP did not include direction to staff or outline appropriate interventions to use with Resident #1 to facilitate adequate personal hygiene.</p> <p>The facility failed to provide supervision to Residents #1 in regards to smoking in the facility. This lack of supervision put 100% of the residents in immediate danger. The facility also failed to provide supervision and a secure environment for Resident #2, who had a history of elopement. This lack of supervision had the potential for immediate danger to this resident and other residents with similar behaviors. Additionally, the facility did not protect residents' rights by failing to provide a safe and sanitary environment. This had the potential to affect 100% of the residents in the facility. Further, the facility failed to implement an NSA or develop a BMP for Resident #1 to describe Resident #1's behaviors which prohibited staff from providing the necessary personal hygiene care. These failures</p>	R 008	<p>A Quality Assurance committee has been formed to monitor and improve quality, training and education issues throughout the facility. All staff in-service training will be documented and results of such reviewed as part of the monthly quality review component. Committee consists of the facility Administrator, facility Nurse, Lead Aid, with oversight by the VP.</p> <p>On September 07, 2007, following one-to-one 24 hour staffing and monitoring of resident #1's behaviors, a meeting was called with the resident's family member, the Ombudsman for the Elderly, a representative from Adult Protective Services, the facility Administrator, VP, VP of Finance, to discuss resident hygiene and general health behaviors and non-compliance with facility smoking policies. Plan for psychological evaluation and possible temporary placement in psychological hospital for that purpose was discussed. It was determined that one-to-one 24 hour staffing/monitoring would continue.</p> <p>On September 13, 2007 an update to Resident #1's NSA and BMP was completed. Staff in-service training was received September 13 and 14 specific to the revised BMP and NSA for Resident #1.</p> <p>On September 14, 2007, after receiving resident #1's approval, and in conjunction with the resident family representative, a representative from the office of the Ombudsman for the Elderly and Adult Protective Services, a physician order was secured and arrangements were made for resident #1's admission to a hospital specializing in psychological evaluation and treatment was secured.</p> <p>Staff training on resident rights, use of the Ombudsman and Adult Protective Services, facility notification policies will be completed by September 19, 2007. This training will be followed by monthly reviews scheduled for October 10, November 09, and December 10, 2007. Quarterly reviews will be scheduled thereafter. Material will be mandatory for all newly hired employees.</p> <p>All staff in-service training and education will be monitored by the Quality Assurance committee. A Quality Assurance committee has been formed to monitor and improve quality, training and education issues throughout the facility. All staff in-service training will be documented and reviewed as part of the monthly quality review component. Committee consists of the facility Administrator, facility Nurse, Lead Aid, with temporary oversight by the VP of Operations.</p>	

Bureau of Facility Standards
STATE FORM

8808

K facility Nurse, Lead Aid, with temporary oversight by VP of Operations.

FORM APPROVED

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 13R584	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED C 08/22/2007
NAME OF PROVIDER OR SUPPLIER ASPEN GROVE ASSISTED LIVING - IDAHO FAI			STREET ADDRESS, CITY, STATE, ZIP CODE 2705 E 17TH ST IDAHO FALLS, ID 83406		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE	
R 008	Continued From page 13 resulted in inadequate care.	R 008			

Bureau of Facility Standards
STATE FORM

5859

KNR/J11

If continuation sheet 14 of 14



IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

LESLIE M. CLEMENT - Administrator
DIVISION OF MEDICAID
Post Office Box 83720
Boise, Idaho 83720-0036
PHONE: (208) 334-5747
FAX: (208) 364-1811

October 9, 2007

Catherine Johnson, Administrator
Aspen Grove Assisted Living - Idaho Falls
2705 E 17th St
Idaho Falls, ID 83406

Dear Ms. Johnson:

On August 22, 2007, a complaint investigation survey was conducted at Aspen Grove Assisted Living - Idaho Falls. The survey was conducted by Rachel Corey, RN, Donna Henscheid, LSW, Karen McDannel, RN and Jamie Simpson, MBA, QMRP. This report outlines the findings of our investigation.

Complaint # ID00003138

Allegation #1: The facility operated more than 30 days without a licensed administrator.

Findings: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.215.03 for operating more than 30 days without an administrator. The facility was required to submit a plan of correction.

Allegation #2: The staff were verbally abusive and demeaning to a resident regarding his hygiene practices.

Findings: Substantiated. However, the facility was not cited due to taking appropriate actions. During the complaint investigation on 8/22/07, 3 out of 10 residents interviewed stated they had witnessed the staff "picking" on the resident but the staff responsible were no longer working at the facility. The facility's regional nurse confirmed that some of the prior staff and administration had been "harsh" but no longer worked at the facility.

Allegation #3: The facility did not provide a clean, safe and sanitary environment.

Findings: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for inadequate care and violating resident rights by not providing a clean, safe and sanitary environment. The facility was required to submit a plan of correction.

Catherine Johnson, Administrator

October 9, 2007

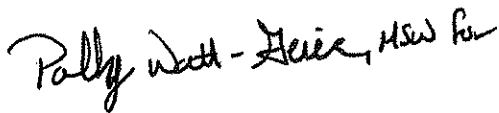
Page 2 of 2

Allegation #4: The facility did not provide a resident with assistance with ADL's as outlined in his NSA.

Findings: Substantiated. The facility was issued a core deficiency at IDAPA 16.03.22.520 for inadequate care for failing to meet the terms of the Negotiated Services Agreement for 2 of 3 sampled residents and failing to provide adequate supervision to 2 of 3 sampled residents. The facility was required to submit a plan of correction.

If you have questions or concerns regarding our visit, please call us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us while we conducted our investigation.

Sincerely,

A handwritten signature in black ink, appearing to read "Donna Henscheid - HSW for".

DONNA HENSCHIED, LSW

Team Leader

Health Facility Surveyor

Residential Community Care Program

DH/sc

c: Jamie Simpson, MBA, QMRP, Supervisor, Residential Community Care Program
Donna Henscheid, LSW, Health Facility Surveyor